Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Trinity Park Surgery Center

Respondent Name
Indemnity Insurance Co of North

MFDR Tracking Number
M4-13-2616-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 12, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting reconsideration of this claim for an additional payment based on the 2013 Texas Work Comp ASC Allowable Rates…"

Amount in Dispute: $44.41

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please accept this as the Carrier's response to this request for medical dispute resolution. It is our position that no additional fees are due…"

Response Submitted by: Broadspire, 8827 N. Sam Houston Parkway N. Suite 110, Houston, TX 77040

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 22, 2013	29880	$44.41	$1.27

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out guidelines for ambulatory surgical center fee guidelines
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers' compensation jurisdictional fee schedule adjustment.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the respondent support payment calculations?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §134.402 states, (f) states in pertinent part, "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR (current year)… The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; or ASC Addenda AA allowable for 29880 = $1,184.89 divided by 2 = $592.45 x (Core Based Statistical Area (CBSA-City Wage Index) 0.9525 = $564.31, 592.45 + 564.31 = $1,156.76 x 235% = $2,718.38. The total MAR for the services in dispute is $2,718.38
2. Review of the submitted information finds the total allowed charges is $2,718.38. The carrier paid $2,717.11. The remaining balance of $1.27 is recommended to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1.27.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1.27 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.